Nova Scotia
Advisory Council
on the Status of
Women

Conseil consultatif
sur la condition
féminine de la
Nouvelle-Écosse

An agency of the
Province of Nova Scotia

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SUBMISSION TO THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES

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INTRODUCTION

The Nova Scotia Advisory Council on the Status of Women welcomes this opportunity to appear before the Royal Commission on New Reproductive Technologies.

The Advisory Council, like many other women's organizations, is gravely concerned at the implications of these technologies for women, and for our society in general. At present, NRTs may benefit some infertile women (and men) whose infertility fits the required criteria for "treatment," and who are among the 10 percent who bring home a baby. We cannot assume, however, that because a certain portion of the population is having its needs met, the benefits of the technology outweigh the costs. All the evidence from a feminist perspective suggests that NRTs will further undermine women's reproductive control.[1]

While some feminists have argued that women will not achieve equality unless they free themselves from reproduction,[2] others have argued that women's reproductive capacity and control over childrearing is at present the source of most of

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[1] See for example Rita Arditti et al. (eds.), Test Tube Women: What Future for Motherhood?, London: Pandora Press, 1985; Gena Corea, The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs, New York: Harper & Row, 1985; Renate Klein (ed.), Infertility: Women Speak Out About Their Experiences of Reproductive Medicine, London: Pandora Press, 1989; and Patricia Spallone and Deborah Lynn Steinberg (eds.), Made to Order: The Myth of Reproductive and Genetic Progress, Oxford: Pergammon Press, 1987.

[2] Most notably Shulamith Firestone in The Dialectic of Sex: The Case for Feminist Revolution, London: The Women's Press, 1979.

our power. Since women do not have equal access to economic and political power, losing ground in reproductive control has very serious implications for women-as-a-group. Will women become obsolete?

The New Reproductive Technologies must be examined in the context of values as well as science. We must recognize that we come to this discussion with our own values about the process of conception, the importance of women's right to control our own bodies and to make informed decisions regarding our own health, the role of science in society, and societal goals in terms of reproduction.

Unfortunately, much of our value system relies heavily on a patriarchal view of the world. The focus of much of the current ethical, legal, and medical literature on reproductive technology is on the notion of "legitimacy," and children's legal relationship to a male--either the biological father (the sperm donor) or the social father. It is our view that this approach is seriously outdated, and the concept of "hereditary succession" no longer meets the needs of our changing society.

Many children are born through sexual intercourse who have no legal father; many, many more have a birth certificate on which a man's name may appear, but, in practice, have no (social) father. When large numbers of men do not emotionally and financially continue to support their offspring after a separation or divorce, with informal state sanction, it is absurd to be concerned unduly about whether those children have any relationship to him in law.

What <u>is</u> important is to ensure for the child future maintenance and support, and for the child, mother, father (if there is one), and gamete donor(s) to be protected from

unnecessary legal action or custody disputes. Such protection for the state and for individuals is relatively easy to accomplish with comprehensive legislation and regulation that, as much as is possible, leaves no room for conflicting interpretations of the law.

It seems likely that infertility will increase over the next several decades. Environmental factors which affect our reproductive health and inhibit or prevent conception are becoming better understood, but with little accompanying change in the environmental situation. In addition, there is no reason to suppose that iatrogenic (doctor-induced) infertility will not continue to rise, since medical intervention in reproductive processes is also on the increase.[3] Sexually Transmitted Diseases (STDs), especially gonorrhoea and chlamydia, are another major cause of infertility.[4] With a larger and larger population unable to have children, demand for reproductive technologies will also increase. It is now that regulations and legislation must be formulated to protect women and men, and the children of the future who will be born of this technology.

We are proposing formalized guidelines and government controls to protect women, men, and children from the suffering that has great potential in the misuse and misapplication of these procedures, and to ensure that it is not individual doctors or clinics, or even the medical profession as a whole, who decide on issues such as access and the appropriateness of particular

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[3] Many of the major causes of infertility are iatrogenic and as such can be largely prevented. Pelvic Inflammatory Disease (PID), a major cause of infertility, can be caused by an IUD, a D&C, or an infection after childbirth, a cesarean, an abortion, or pelvic surgery, among other things.

[4] Money spent now on education and prevention can do much to lessen future infertility.

practices and technologies. We, as a nation, must have all of our voices heard. Many of us are afraid, and our fear is not to be taken lightly.

In our recommendations to this Commission, we put forward a variety of approaches in an effort to achieve a technology which we, as Canadians, need not fear:

- an outright ban on certain practices/techniques/ technologies;
- legislation to control, restrict, or prohibit certain practices; and
- clarification and universalization of contracts to explain relationships and protect the parties involved through the court system.

We hope the Commission will strongly recommend to the federal government that more formalized guidelines, regulations, and legislation are imperative <u>now</u> to ensure a controlled, ethical approach to reproductive medicine.

MEDICALLY-ASSISTED CONCEPTION TECHNIQUES

<u>Donor Insemination</u>

Contrary to medical assertions, donor insemination (DI) is not a medically complex procedure. Many women have self-inseminated using a syringe or turkey baster, and many doctors, nurses, or other medical technicians have in the past been willing to inseminate women in their offices using donor sperm.[5]

DI may take place in a clinic using the same basic procedure as at home or in the doctor's office, or it may be used in

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[5] Increasingly, however, fear of AIDS is making both individual women and doctors hesitant to inseminate.

conjunction with in vitro fertilization (IVF) or any of the other medically-assisted conception techniques listed below, or with fertility drugs; the only difference is that donor sperm is used instead of sperm from the woman's male partner (if she has one).

DI was formerly a secret procedure and, to a large extent, remains so. It is estimated that up to 90 percent of heterosexual DI couples who go through clinic insemination keep the fact secret that the child is not biologically related to the father. Donor "matching" may be carried out with the male partner to ensure that physical characteristics are as similar as possible.

Both partners are required to sign a witnessed consent form. In some countries, a DI child is considered illegitimate, which encourages couples to lie on the birth certificate and perhaps more importantly, to the child her/himself. In some countries, the husband's name goes on the birth certificate--either because of protective legislation, or simply because no one knows that he is not the biological father[6]--he is considered the child's legal father and has the same obligation to pay child support in the event of divorce.[7] In Canada, only a few provinces have laws regulating DI relationships, and there is a lack of consistency in the approach to such relationships on a national basis.

The woman seeking insemination can use frozen, banked sperm, or in some clinics she can bring a man with her who is willing

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[6] In the absence of legislation, such a claim to paternity could be construed as a false entry of birth under Section 377 of the Canadian Criminal Code.

[7] Some men have tried to claim non-paternity, or that the woman was inseminated without their knowledge and consent, in an effort to avoid paying.

to donate fresh sperm. For single and lesbian women who do not want to share parenting with the donor and who want to protect themselves from future custody disputes, having a known donor can be less than ideal.

Legislation is required to ensure that the donor, having signed a consent form, has no legal rights to the child and, equally, cannot be sued for child support or inheritance. The partner of the woman receiving DI, having signed a consent form, should be the legal father of the child and should have the same obligations for child support and inheritance as a biological father.

The male partner of the woman receiving DI, the social father who will participate in the child's life (to whatever degree), is clearly the child's father. While his name may appear on the birth certificate, we believe that indication should also be made that the child was conceived by donor sperm.

The adoption situation in Canada is teaching us that children have a right and a need to know their biological parentage. We are not suggesting that DI children be provided with the name or other identifying information about the biological father, but that the child has a right to know the medical history, physical characteristics, and particular talents of their biological parents. Most importantly, children need to know they are not the biological offspring of their (social) father for the same reasons that adopted children need to know --this knowledge in no way, in and of itself, weakens the bond between children and their (social) parents.

In addition to these important social and emotional reasons, there are medical reasons which make "knowing" imperative. If there are health issues to be addressed in the next generation as a result of today's "fertility" drugs (similar to what we

are now facing in relation to tracing and informing DES-exposed daughters and sons), DI (and IVF) children will need to know how they were conceived and what drugs their mothers were given prior to conception and during early pregnancy.[8]

Some people believe that individual contracts outlining the rights and obligations of each party are sufficient and will be upheld by the courts, but in cases where there has been a known donor, he has in some instances successfully sued for access and/or joint custody of the child, particularly in cases where the mother is a single heterosexual woman or a lesbian (in other words, where there is no other "father-figure").

In some states in the United States, the law regulating DI covers only insemination that is performed by a physician, and this appears to be the approach of some of the provinces at present.[9] Self-insemination cannot possibly be regulated, nor should it be. It is ludicrous to suggest that insemination by penetration of the penis into the vagina is legal, but that placement of the sperm first into a container and subsequently inserted into the woman's vagina through any number of safe

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[8] In addition, in the Report of the Advisory Committee on the Storage and Utilization of Human Sperm to the Minister of National Health and Welfare, concern is expressed over "the development of unwarranted anxiety that would arise in a child if his or her social father subsequently developed an inheritable disease" (43:1981).

[9] See The Ontario Law Reform Commission Report on Human Artificial Reproduction and Related Matters, 1985; The Law Reform Commission of Saskatchewan, Proposals for a Human Artificial Insemination Act, 1987; and The Report of the Advisory Committee on the Storage and Utilization of Human Sperm to the Minister of National Health and Welfare, 1981.

methods is somehow illegal.[10]

It is vital that laws dealing with DI apply equally to self/partner and nurse/technician inseminations. Clauses arguing that donor insemination is a "medical practice," or that it must be performed "under the supervision of a physician," should be struck from all relevant legislation. Women and their children have a right to protective legislation regardless of how or by whom the insemination was performed.

In Vitro Fertilization-Embryo Transfer (IVF-ET) and Other Related Procedures[11]

The Advisory Council believes there is an important distinction to be made between donor insemination and in vitro fertilization (and related techniques), not only in financial terms but also in terms of the complexity and invasiveness of the procedures. Donor insemination can be performed quickly and easily either in or outside of a medical setting with a minimum of "implements," is relatively inexpensive, and has no "side-effects" other than the desired pregnancy (assuming safe sperm is used). Indeed, if women had greater access to safe sperm,[12] access to medically-assisted insemination would be less crucial.

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[10] Medical assertions as to the medical "risks" involved in non-medical insemination are completely unfounded. Claims of infection, severe abdominal pain, shock, and death, are based on intrauterine insemination rather than intra-vaginal insemination.

[11] We include in this section Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) also known as Tubal Embryo Transfer (TET) or Tubal Embryo Staging Transfer (TEST), and Pronucleus Stage Transfer (PROST).

[12] In other words, if there was anonymous AIDS testing.

IVF, on the other hand, requires complex medical equipment and procedures, and is extremely expensive and time-consuming. Some of the procedures involved in IVF are painful for women and may have serious side-effects in terms of women's overall health.

The best success rate for this procedure at any clinic is in the vicinity of 10-15 percent; it is much lower (or nil) in some clinics. There are estimated to be over 20,000 IVF babies worldwide. The cost varies from $3,000-$7,000 a cycle (one attempt), including drugs. The waiting list for some clinics is two to three years.

At present, access to infertility clinics is usually limited to heterosexual married couples who are financially and psychologically "stable." Usually, the couple is white, since in many areas there is a very limited (or no) supply of sperm from non-white men, or subtle racism ensures that non-whites are not referred to the clinic. Lesbian couples, or single lesbian or heterosexual women, have little or no access to this technology. Low-income women/couples have no access to this technology.[13] For some procedures, the couple/family must be able to survive on one salary, since the woman is required to spend, on a daily basis, several hours at the clinic, sometimes for many weeks or months. Most single women who support themselves would clearly be unable to participate; few employers are flexible and supportive enough for the woman to retain her job. Women-as-a-group do not have access to this technology; rather, certain women are being <u>selected</u> to receive treatment (or to look at it another way, to be experimented on).

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[13] Ontario is the only province in Canada to cover some of the costs for hospital-based infertility treatments under its provincial health insurance.

There are consent forms that cover all of the stages of IVF (including, where applicable, what is to happen to embryos if more are retrieved than can be used, or to frozen embryos if the couple should divorce or die). Usually 3 or 4 embryos are transferred into the woman's uterus in one cycle, but as many as 10 or 12 eggs may have been retrieved at one time.[14] The extra embryos may be destroyed, donated to other IVF women who do not ovulate, used for research purposes, or frozen for later use in either implantation or research purposes. Some programs stipulate a time period after which the frozen embryos must be destroyed or donated, for example, after 10 years or when the woman turns 45. Women undergoing IVF may consent to anonymously donate eggs/embryos to other women. As well, some clinics allow known donors; in other words, the woman brings in her sister or a friend to donate an egg for her. This practice is extremely controversial for several reasons. It is felt that the friend/sister may feel compelled to donate an egg against her better judgement because of the close nature of her relationship with the woman undergoing IVF. There are also concerns about the donors relationship to the child if one is born.

The implications of this kind of technology are deeply disturbing to us. We recognize, on the one hand, the pain of many women who are presently unable to have a baby, and the hope that this technology holds out to them. We know, also, that the practice of medically-assisted conception is unlikely to stop, since we as a society (and in particular the medical

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[14] In Nova Scotia, it is the policy of the Grace Maternity Hospital that all of the viable ova that are retrieved are re-implanted after fertilization into the woman who has produced them. The maximum number of embryos ever transferred is seven, but twins is the largest multiple birth that has resulted. (Conversation, Nursing Director, Endocrine and Infertility Centre, Grace Maternity Hospital, September 19, 1990)

profession) cannot accept anything less than complete control over the biological and reproductive processes of our bodies. That there is a time to say "enough is enough" would never occur to us.

Individual women who are served by this technology may also find themselves on a treadmill of increasingly invasive, costly, and time-consuming interventions, with little opportunity to re-examine their priorities or call a halt to the process. It becomes more and more important for women who access these technologies to recognize all of the ramifications involved in their decisions, and to be given the tools to make active, informed choices concerning their own reproductive future, for those decisions will have implications far beyond their private family lives.

DIAGNOSTIC TESTS

Fetal/Embryo Testing

Prior to implantation, if the embryo is found to be "defective" through embryo biopsy, it is discarded. There is much controversy over whose definition of "defective" is used --and much concern that it is mostly white, male, able-bodied doctors who are making the decisions.

There is a great deal of concern from a wide range of groups representing people with various disabilities that reproductive technologies are moving us toward a greater intolerance of any disability or "difference" because the demand for "perfect" babies is increasing. Genetic screening and manipulation allows for greater and greater control of not only genetic diseases and disabilities, but also of physical (and someday, personality?) characteristics. Medical terminology is fraught with judgement--disabled fetuses are labelled "imperfect," "defective," and even "abberations."

In many cases, the presence of a genetic abnormality does not guarantee the development of a particular disease but may merely indicate a genetic propensity to the disease. Environmental and social factors may contribute as well. In addition, there is no way of knowing how severe or debilitating a particular condition will manifest itself in any given individual, and there is a great range of abilities possible, perhaps partly dependent on environment, of known genetic diseases (such as Down's Syndrome or Spina Bifida).

Amniocentesis or chorionic villus sampling (CVS) should be offered only after a woman has decided she would definitely abort if she is carrying a child with a genetic abnormality, and/or which fetal abnormalities she would choose to abort, or only if she feels she needs the information to be better prepared for a disabled child. No woman should be forced or coerced into carrying a disabled fetus to term against her wishes, but counselling should be encouraged prior to decision-making, and clear information should be made available on the range of functioning/disability that is possible for each detectable genetic disease.[15] There may be a vast difference between painful death shortly after birth, and a valuable but "different" life.

Prospective parents should examine closely their assumptions about the intrinsic worth of differently-abled children. We need to encourage the view that having a disabled child is yet one more opportunity for caring adults to learn and grow. Clearly, appropriate social support systems must be in place

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[15] Legal claims filed by parent(s) arising from the presence of a congenital disability or genetic disease in their baby can be largely prevented by ensuring that women/couples are fully informed regarding the possibility of having a disabled child, as with any pregnancy. The willingness of the courts to consider such claims serve only to commodify "perfect" babies.

for disabled children and their parent(s). Women and men need adequate information, education, and financial and emotional support if they choose to proceed with the pregnancy.

Sex Selection

Sex of the fetus can be determined through embryo biopsy prior to implantation, or through CVS or amniocentesis during pregnancy. If a woman/couple want(s) a child of a particular sex, then only those embryos may be implanted using IVF or a variation technique. If the woman is already pregnant, the only solution to a child of the "wrong" sex is, of course, abortion. There is some consensus in both the women's and medical communities that abortion solely for sex selection is unethical and has serious implications for distortion of sex ratios within a given population, since in most cultures greater value is placed on boy children. Some feminists are also concerned about the implications for wanting only a child of a particular sex on an individual basis--what does this say about sex-role stereotyping and how "little girls" or "little boys" will be raised?

A distinction has been made in the medical community between sex selection for "social" reasons and sex selection to lessen the chances of sex-linked diseases. There is a fine line here, and once again it is the physician who appears to be in control of the distinction.

The Advisory Council recommends that diagnostic testing for the purposes of sex selection for social or economic reasons be banned. Where there is evidence of a sex-linked genetic disease, women (or couples) should be informed of the social implications of their decision, as well as the medical ones.

FERTILITY DRUGS

All of the drugs used to bring on or regulate ovulation or to "super-ovulate" women are associated with potentially serious and long-reaching effects to women and to their children if pregnancy is achieved. Women are not being adequately informed of these risks. Possible (and not uncommon) side-effects include hot flashes; weight gain; rash; dry vagina; abdominal discomfort, pain, nausea and vomiting; breast tenderness; fever; dizziness and headaches; bone loss; blood clots; hirsutism; ovarian cysts; overstimulation or rupture of the ovaries; infertility; depression, anxiety, and insomnia.[16] Some of the drugs are also known to cause higher rates of congenital abnormalities in the fetus, miscarriages, premature births, and multiple births.

We simply do not know enough about the long-term consequences of these "fertility" drugs, although there are indications that are serious enough to warrant immediate attention. In particular, the drug Clomid is chemically similar to Diethylstilbestrol. Even though it is not taken during pregnancy, drug residue remains in the woman's body for weeks after it is administered (and is therefore present during early pregnancy). The effects of the drug may not be known until this generation of Clomid babies reaches childbearing age. Clomid has been and continues to be prescribed to DES daughters who are not ovulating regularly!

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[16] See The Physician's Desk Reference for the drugs Clomiphine Citrate (brand names Clomid, Serophene), Human Chorionic Gonadotropins (Profassi), Human Menopausal Gonadotropins (Pergonal), Corticosteroids (Prednisone, Prednisolone, Dexamethasone), FSH (Metrodin), GnRH Analogues (Buserelin, Leupron, Leuprolide), Bromocriptine (Parodel, Serocriptin), anti-androgens (Cyproterone Acetate, Spironolactone), and Danazol (Cyclomen, Danocrine).

We recommend that the medical literature on the drug Clomid be reviewed, and if even one study exists to seriously question the safety and long-term effects of this drug,[17] that it be banned from use entirely, and that further study be undertaken to adequately assess all other drugs used in medically-assisted conception, to determine the effects these drugs are having on women's bodies. There is a danger that women who are undergoing infertility "treatment" may themselves negate the serious effect of these drugs in order to achieve that much-wanted pregnancy.[18]

OTHER RELEVANT TECHNIQUES/PROCEDURES

Selective Reduction

If a multiple pregnancy occurs, through stimulation by fertility drugs or by implanting a large number of embryos, the physician may reduce the number of fetuses to two or three by selecting some for "termination." This is done using transvaginal or transabdominal ultrasound, inserting a needle through the woman's uterus, and injecting a solution of potassium chloride into the heart(s) of the selected fetuses, which stops the heart(s). The procedure is usually done between 8 and 13 weeks, when the fetuses are 1 to 3 inches

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[17] As in, for example, S. McCormack and J.H. Clark, "Clomid Administration to Pregnant Rats Causes Abnormalities of the Reproductive Tract in Offspring and Mothers," Science, 204: 629-631, 1979. See also Anita Direcks "Has the Lesson been Learned?: The DES Story and IVF", in Spallone and Steinberg (eds.), Made to Order: The Myth of Reproductive and Genetic Progress, Oxford: Pergamon Press, 1987.

[18] On a recent television talk show ("The Shirley Show") on IVF, one member of the panel, a woman who had undergone IVF and achieved a pregnancy, stated adamantly that she had experienced "no physical pain" in connection with her infertility "treatment". A short time later, this same woman disclosed that she had been super-ovulated through the use of fertility drugs, and that her pain and fear were so great that "I thought I was going to die!"

long, to those fetuses most accessible to the needle. The dead fetuses are usually re-absorbed by the woman's body.

There is a risk of bleeding, uterine contractions, or infection--in other words, the woman may miscarry the entire pregnancy as a result of this procedure. We could find no information regarding the emotional or psychological effects of this technique, nor indeed any indication of how commonplace it might be, but doubtless women find it a very difficult and painful experience.

The Advisory Council believes that this practice is extremely problematic and should not be permitted. Multiple pregnancies where there are more than three fetuses are almost invariably a medically-created condition. The problem can be solved before it gets to this point by transferring fewer embryos (a maximum of two or three) back into the woman, by limiting the use of fertility drugs, or by choosing to forgo a cycle if the woman's ovaries have been overstimulated (detectible on ultrasound).

Embryo and Fetal Research

Research which involves manipulation of human gametes in an effort to duplicate or alter the physiological makeup of the human species, such as cloning, transgenics, and chimeras, should be banned absolutely. Any research which purposefully locates gestation outside of the woman's uterus, such as ectogenesis and male pregnancy should also be banned. These things have very serious social implications for particular groups of individuals and for society as a whole--implications which cannot be predicted nor necessarily controlled. No federal or provincial funding for research or publication of research in these areas should be acceptable in Canada, or by Canadian scientists working elsewhere.

Other research should be guided by strict adherence to the principal of practical and ethical usefulness to enhancing or promoting the health (in its narrowest sense) of individuals.

Fetal Spare Parts

The Advisory Council recommends that research involving fetal tissue from aborted fetuses be permitted, providing that the abortion was not obtained for the purpose of donating tissue, and providing that the woman undergoing the abortion is recognized as the "owner" of the fetal tissue and has given her informed consent to whatever specific and particular research endeavour is planned.

OTHER RELATED ISSUES

Gestational Mothering (Surrogacy)[19]

A gestational mother agrees, is contracted, or is coerced into bearing a child which is (usually) genetically related to the male partner, and sometimes to the woman partner of a heterosexual couple.[20] The man may inseminate the gestational mother's egg either through intercourse, by DI, or by IVF. If the woman partner's egg is used, IVF (or a variation) is necessary. The gestational mother may be the sister, mother, or friend of one of the couple, or may be a stranger.

There is a great deal of concern that a "breeding class" of poor women may develop if this practice becomes commonplace. Gestational mothers to date have in general been low-income

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[19] Since we are making the argument that it is the woman who carries the child in utero who is most appropriately the child's mother, the term "Surrogate" is wholly inaccurate.

[20] In some cases, gay men have contracted with a woman to carry a child that may or may not be biologically related to one of the partners, or to the single gay man.

women who agree to carry babies for financial as well as (perhaps) altruistic reasons. For economic reasons, they are also the group of women least likely to be awarded custody should they change their minds about relinquishing the infant to the contracting couple, and are least likely to have access to medical and legal services.

In some countries, gestational mothering is legal only as long as no payment is received for the "service," but this does not adequately protect women from abuse.

The Advisory Council recommends that "surrogacy contracts" made prior to the conception or birth of a child not be recognized by the courts as legal documents under any circumstances. If after the birth of a child, a woman chooses to relinquish her child for adoption to a particular couple, then the legislation that governs private adoptions should prevail.

In most countries the legal mother is the woman who gives birth to the child(ren), regardless of whose genetic material is used, since gestational and genetic mothering issues have not been addressed. This should be ensured in law: the gestational mother should always be the legal mother of the child, regardless of whose sperm or egg is used. She should be entitled to the same protection and rights,[21] under the Family and Children's Services Act (or other provincial equivalent), as mothers who consider relinquishing a child for adoption. Under no circumstances should she be required to prove her "fitness" to parent in a court of law.

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[21] Including the right to change her mind about relinquishing the child within a specified time period after the birth.

Ownership

Who owns the sperm, the eggs, the embryos, the fetus, the fetal tissue? The donor, the recipient, the woman, the couple, the physician, the public? Legal battles have already occurred over ownership of some of these reproductive "products." Central to this debate is the legal definition of some of these products. At present, for example, ova (and presumably embryos) are not considered a human tissue[22] nor a bodily fluid and so coverage falls through the cracks of legislation governing these substances.

We should perhaps think in terms of "legal guardianship" or "stewardship" rather than "ownership," since the legal status of the products of conception is at the crux of this debate. The Advisory Council recommends the following points be enacted clearly and consistently in law across Canada (see Appendix):

- In the case of sperm or ova donation, where the intention of the donor is solely to donate her/his reproductive material for others' use, the donor, having signed a consent form, should have no legal relationship to any child that may result. Gametes are relinquished to a recipient, with the clinic as temporary guardian or caretaker, and all parental rights and responsibilities (including the right to information about offspring) on the part of the donor are concurrently relinquished.

- In cases where ova donation occurs as a secondary intention, the woman donor should retain some control over decisions as to the use of the surplus. In other words, if more ova are

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[22] In its Report on Human Artificial Reproduction and Related Matters (1985), the Ontario Law Reform Commission takes the stand that sperm would likely fall under the Human Tissue Gift Act.

removed than can be re-implanted from a woman who is herself undergoing IVF, she retains the right to decide whether the surplus are to be donated (at which time she relinquishes control), frozen, used for regulated research purposes, or destroyed.

- Surplus embryos which are the genetic material of each member of a couple should belong jointly to the couple, who together retain the right to decide how their embryos are to be used. In the event of one individual's death, guardianship reverts absolutely to the other. In the event of divorce, separation, or dispute between the individuals regarding the future of any surplus embryos, they should be frozen for the designated "safe" period (if facilities exist), after which time they should be destroyed if there is no resolution of the conflict.

- Embryos that are the genetic product of one member of a couple combined with donor ova or sperm should belong solely to that genetically related individual in the event of divorce, separation, or dispute over the outcome of any surplus embryos.

- It should be a criminal offence to remove genetic material from a woman's reproductive organs, whether or not those organs have been removed from her body, without her knowledge and informed consent. Ova should under no circumstances be removed from women undergoing hysterectomies, tubal ligations, etc. as a matter of routine practice.

Rights

Fundamental to this whole discussion is of course the question, Is there a fundamental human right to have a child? Or, Is there a fundamental right for some people to have a

child? If so, which people, and who will make the decisions? Many women do not have equal access to these technologies for a variety of reasons: financial status, marital status, employment status, sexual orientation, age, race, disability, and geographical location.

We strongly believe that no one has the right to force a woman to have a child against her will. Equally, no one has the right to prohibit a woman from having a child if she is able to do so. Reproductive choice and control must rest with the individual. The Advisory Council recommends that women should not be denied the opportunity to have children based on social or financial criteria. Infertility should mean simply the inability to conceive children, for whatever reason, including simple non-access to "safe" sperm.

INDICATIONS FOR FURTHER STUDY AND DISCUSSION

Access

If we are going to support some of the reproductive technologies available to enable infertile women to have greater reproductive choice, then what can/should we do to ensure access to all women, regardless of marital status, sexual orientation, skin colour or ethnic background? How will we ensure access for women regardless of our economic status, unless we recommend that it be covered by our health care insurance? Should shrinking health care budgets be used to support these very expensive techniques that benefit only a few, when basic health needs are going unmet in other areas?

Related Labour and Birth Technologies

Are labour and birth technologies used more frequently on women who have accessed medically-assisted reproductive technologies, since they are automatically considered high risk? Or are these women considered high risk for other

reasons, such as maternal age? Are most IVF babies born by cesarean section?

At the infertility clinic at the Grace Maternity Hospital in Nova Scotia, follow-up during pregnancy, labour, delivery, and post-natal care for mother and infant are provided by physicians who may not even know that the child is the result of medically-assisted conception techniques. What implications might this have for the health of the child and for records of genetic abnormalities and family medical histories?

Privacy

Medically-assisted conception techniques are generally a very secretive affair. Many couples choose not to tell family, friends, or even the child about the nature of the conception. There are times, however, when the couples' names and the name of the child become household words across the country or around the world, particularly where a physician is seeking publicity for accomplishing a "first" (Louise Brown is a good example). What are the implications of this for the families and children involved? Do clients need to sign consent forms to allow physicians to release their names to the media? Do any guidelines presently exist?

Follow-up studies are vital to determine the health and psychological/emotional effects of all of these procedures on the donor(s), parent(s) and child(ren) involved, but the secrecy that presently surrounds DI and IVF (and related techniques) makes such data difficult to obtain. Is it ethical to invade the privacy of some individuals to determine long-term effects that may otherwise be difficult to assess and may have serious implications for society as a whole? Certainly, the approval of a particular drug would not be condoned without carefully monitored studies indicating that

the drug is not harmful or that the benefits outweigh the costs. Perhaps the psychological effects of treatment should be considered in the same light as physiological outcomes. Also, if mandatory follow-up is done, women/couples/children may be more likely to have access to any counselling they may feel they need.

Emotional Repercussions

Will women who have achieved medically-assisted pregnancy be able to complain of fatigue and physical effects of pregnancy? Will they allow themselves to feel normal anger, resentment, and frustration towards their baby/child in light of all the effort they put into getting pregnant? Women who achieve pregnancies the "normal" way deny these feelings too much already. Will they feel like "bad" mothers when they experience the depth of negative feelings that are inevitable, and normal, in raising a child?

Conversely, are IVF babies more likely to be over-protected, or to be subject to unrealistically high expectations for achievement, because they were very wanted children and cost their parent(s) much in terms of emotions, health, and finance?

Global Population Issues

Millions of dollars are spent on reproductive technologies in the developed nations of the world to enable mostly white, mostly wealthy women to have babies. In many developing countries, sterilization abuse and dumping of unsafe contraceptives is more the norm, funded and supported by the same governments that are funding IVF research. This amounts to nothing less than cultural and racial genocide. Sex-selection procedures in countries where one-child policies exist, notably China and Thailand, result in a high incidence of female feticide and infanticide. We cannot consider the

impact of NRTs in Canada without this global perspective.

CONCLUSION

Clearly, we want to be able to support women's decisions--women should have access to technology that allows them greater reproductive choice--as long as that technology does not serve to oppress other women. It is not clear to us that these technologies do in fact deliver what they promise: miracle babies. What we can see is women all over the world suffering side effects, emotional stress, and economic hardship because of these technologies; women in some parts of the world being denied any reproductive choice; and women and men in this country confused and fearful of the future which this "promise" holds.

We strongly recommend the formation of a permanent federal regulatory body to oversee the implementation of comprehensive and consistent legislation across Canada. This body should include but not be limited to representatives from women's organizations, infertility support networks, legal, medical, and ethics professionals, and the disabled.

SUMMARY OF RECOMMENDATIONS

The Nova Scotia Advisory Council on the Status of Women recommends:

1) that the partner of the woman receiving donor insemination, having signed a consent form, should be the legal father of the child and should have the same obligations for child support and inheritance as a biological father. While his name may appear on the birth certificate, indication should also be made that the child was conceived by donor sperm;

2) that children resulting from medically-assisted conception have a right to know the medical history, physical characteristics, and particular talents of their biological parents;

3) that laws dealing with donor insemination apply equally to self/partner and nurse/technician inseminations. Clauses arguing that donor insemination is a "medical practice," or that it must be performed "under the supervision of a physician," should be struck from all relevant legislation;

4) that amniocentesis or chorionic villus sampling (CVS) be offered only after a woman has decided she would <u>definitely</u> abort if she is carrying a child with a genetic abnormality, and/or which fetal abnormalities she would choose to abort, or only if she feels she needs the information to be better prepared for a disabled child;

5) that diagnostic testing for the purposes of sex selection for social or economic reasons be banned. Where there is

evidence of a sex-linked genetic disease, women (or couples) should be informed of the social implications of their decision, as well as the medical ones;

6) that the medical literature on the drug Clomid be reviewed, and if even one study exists to seriously question the safety and long-term effects of this drug, that it be banned from use entirely, and that further study be undertaken to adequately assess all other drugs used in medically-assisted conception to determine the effects these drugs are having on women's bodies;

7) that the practice of selection reduction is extremely problematic and should not be permitted;

8) that research which involves manipulation of human gametes in an effort to duplicate or alter the physiological makeup of the human species, such as cloning, transgenics, and chimeras, should be banned absolutely;

9) that any research which purposefully locates gestation outside of the woman's uterus, such as ectogenesis and male pregnancy should be banned;

10) that other research should be guided by strict adherence to the principal of practical and ethical usefulness to enhancing or promoting the health (in its narrowest sense) of individuals;

11) that research involving fetal tissue from aborted fetuses be permitted, providing that the abortion was not obtained for the purpose of donating tissue, and providing that the woman undergoing the abortion is recognized as the "owner" of the fetal tissue and has

given her informed consent to whatever specific and particular research endeavour is planned;

12) that "surrogacy contracts" made prior to the conception or birth of a child not be recognized by the courts as legal documents under any circumstances. If after the birth of a child, a woman chooses to relinquish her child for adoption to a particular couple, then the legislation that governs private adoptions should prevail;

13) that the gestational mother always be deemed the legal mother of the child, regardless of whose sperm or egg is used. She should be entitled to the same protection and rights, under the Family and Children's Services Act (or other provincial equivalent), as mothers who consider relinquishing a child for adoption. Under no circumstances should she be required to prove her "fitness" to parent in a court of law;

14) that, in the case of sperm or ova donation, where the intention of the donor is solely to donate her/his reproductive material for others' use, the donor, having signed a consent form, should have no legal relationship to any child that may result. Gametes should be relinquished to a recipient, with the clinic as temporary guardian or caretaker, and all parental rights and responsibilities (including the right to information about offspring) on the part of the donor should be concurrently relinquished;

15) that, in cases where ova donation occurs as a secondary intention, the woman donor should retain some control over decisions as to the use of the surplus. In other words, if more ova are removed than can be re-implanted from a woman who is herself undergoing IVF, she should

retain the right to decide whether the surplus are to be donated (at which time she relinquishes control), frozen, used for regulated research purposes, or destroyed;

16) that surplus embryos which are the genetic material of each member of a couple should belong jointly to the couple, who together retain the right to decide how their embryos are to be used. In the event of one individual's death, guardianship reverts absolutely to the other. In the event of divorce, separation, or dispute between the individuals regarding the future of any surplus embryos, they should be frozen for the designated "safe" period (if facilities exist), after which time they should be destroyed if there is no resolution of the conflict;

17) that embryos which are the genetic product of one member of a couple combined with donor ova or sperm should belong solely to that genetically related individual in the event of divorce, separation, or dispute over the outcome of any surplus embryos;

18) that it be a criminal offence to remove genetic material from a woman's reproductive organs, whether or not those organs have been removed from her body, without her knowledge and informed consent. Ova should under no circumstances be removed from women undergoing hysterectomies, tubal ligations, etc. as a matter of routine practice;

19) that women should not be denied the <u>opportunity</u> to have children based on social or financial criteria; and

20) that a permanent federal regulatory body be formed to oversee the implementation of comprehensive and consistent legislation across Canada. This body should

include but not be limited to representatives from women's organizations, infertility support networks, legal, medical, and ethics professionals, and the disabled.

WHO OWNS WHAT?

BEFORE DONATION	AFTER DONATION	SURPLUS
SPERM		
1) Male Donor[1] (Clinic Insemination)	Relinquished to recipient with clinic as temporary caretaker until the time of insemination; after insemination, individual female recipient	• Another recipient • If none, then frozen for designated "safe" period to be implanted in recipient(s) at a later date • If none, then used for regulated research purposes • Or destroyed
2) Male Donor[1] (Self-Insemination)	Individual female recipient	• No surplus
OVA		
3) Female Donor	Female donor (ova leave her body only temporarily)	• Another recipient with donor's permission; if no permission or if no recipient, then according to donor's wishes: a) Fertilized and frozen for designated "safe" period b) Used for regulated research purposes c) Destroyed
4) Female Donor[1]	Relinquished to recipient, with clinic as temporary caretaker until there is a designated recipient	• Another recipient; if none, then same as (3)

[1] Donor has no parental rights or responsibilities and no right to information about recipient or offspring.

WHO OWNS WHAT?

BEFORE DONATION	AFTER DONATION	SURPLUS
EMBRYOS		
5) Individual Male and Female Donors	Relinquished to recipient, with clinic as temporary caretaker until there is a designated recipient	• Another recipient; if none, then same as (3)
6) Individual Male and Female Donors	Individual male and female donors; embryos that are the genetic product of each individual in a couple belong jointly to the couple	• In the event of one individual's death, ownership reverts absolutely to the other. • In the event of divorce, separation or dispute between the individuals regarding the future of any surplus embryos, they should be frozen for the designated "safe" period, then destroyed (if there has been no resolution of the conflict) • Embryos that are the genetic product of one member of a couple combined with donor ova or sperm belong solely to that genetically related individual in the event of divorce, separation or dispute over the outcome of any surplus embryos.
FETAL TISSUE		
7) Female Donor	Relinquished to recipient (with informed consent), with hospital as temporary caretaker	• Another recipient; if none, destroyed